COMMONWEALTH OF KENTUCKY
DEPARTMENT OF PERSONNEL
OFFICE OF PUBLIC EMPLOYEE HEALTH INSURANCE

HEALTH INSURANCE UPDATE FORM

NOTE: ***You CANNOT ADD or DROP dependents using this form***

SHADED SECTIONS MUST BE COMPLETED BY THE INSURANCE COORDINATOR

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER	COMPANY NUMBER
NAME	COMPANY NAME

DOES EMPLOYEE HAVE COMMONWEALTH CHOICE? YES NO

☐ TERMINATION

DATE EMPLOYMENT TERMINATES_____ DATE INSURANCE TERMINATES_____

☐ REINSTATE

☐ TRANSFER → *TO BE COMPLETED BY THE NEW COMPANY*
→ *CANNOT MAKE CHANGES TO CURRENT COVERAGE*

OLD COMPANY #_____ NEW COMPANY #_____ DATE EMPLOYMENT CHANGED _____

TERMINATION DATE OF INSURANCE FROM OLD COMPANY #_____ EFFECTIVE DATE OF INSURANCE AT NEW COMPANY #_____

CURRENT COVERAGE **PLAN CHOICE**_____ **LEVEL** S PP C F Waive

OPTION A B **CROSS REFERENCE?** Y

OTHER CHANGES

☐ **NAME** **NEW** _____

PREVIOUS _____

☐ **NEW ADDRESS** _____

COUNTY CODE _____

☐ **SSN** **CORRECT**_____ **INCORRECT** _____

☐ **DATE OF BIRTH** _____

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

WHITE – ENROLLMENT INFORMATION BRANCH YELLOW – EMPLOYER PINK – EMPLOYEE Revised 05.20.03